

**Noosa General Practice**  
NEW PATIENT DETAILS FORM

Personal Details	Your full name: (As it appears on Medicare Card):	
	Known as:	
	Date of Birth:	
	Patient Home Address:	
	Patient Postal Address:	
	Telephone Contacts: (Please tick which numbers you consent to messages left)	Home: <input type="checkbox"/> Message Permission <input type="checkbox"/> Mobile: <input type="checkbox"/> Message Permission <input type="checkbox"/> Work: <input type="checkbox"/> Message Permission <input type="checkbox"/>
Contact	Do you accept SMS Message	Yes / No (please circle)
Email	Email address:	
Cards	Medicare Card Number:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Ref# <input type="text"/> Expiry date <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	<b>Centrelink</b> Health Care Card/ Pension Card  <i>(please circle one)</i>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Expiry date <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	Veterans Affairs Card Number	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	White cards specify condition:	[ _____ ]
NOK	Name of Next of Kin: Or Emergency contact	Name:
	Contact Details:	Home: _____ Relationship: _____ Mobile: _____ Work: _____
Ethnicity	<b><i>This field is required to be completed</i></b>  <b><i>"Where you were born"</i></b>  <b><i>(Please tick)</i></b>	<input type="radio"/> Australian (Non indigenous) <input type="radio"/> Australian Aboriginal <input type="radio"/> Australian South Sea Islander <input type="radio"/> Torres Strait Islander  Other (please state) _____
Recall Consent	Providing preventative care	I consent to Noosa General Practice contacting me in regard to due appointments relating to my ongoing health care.
Privacy Consent	Use and disclosure	I consent to use of my personal health information by Noosa General Practice <b><i>(see more information on the reverse of this page)</i></b>
Signed Consent	Signature: (Please record relationship if completing this form on behalf of the patient who is under 16 yrs or other)	

## **Health Information Collection and Use Consent Form** **Noosa General Practice**

As a patient of our medical practice we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care needs.

We aim to protect the privacy and secure storage of your health information. You can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information.

We require your consent to collect personal information about you and to use the information you provide in the following ways. Please read this consent form carefully, and sign where indicated below.

- Administrative purposes in running our medical practice and ensuring up-to-date patient demographics.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following referrals. This may occur by sharing health information using the National Digital Health Record system known to you as 'My Health Record'. This may occur by sharing de-identified information for data quality assurance or research to improve individual and community health care and practice management.
- Disclosure to other doctors in the practice, locums etc. attached to the practice for the purpose of patient care and teaching.
- For research and quality assurance activities to improve individual and community health care and practice management. Usually information that does not identify you is used but should information that will identify you be required you will be informed and given the opportunity to "opt out" of any involvement.
- To comply with any legislative or regulatory requirements eg notifiable diseases.
- For reminder letters which may be sent to you regarding your health care and management.

***You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you.***